

10th Conference Recommendations

Note: this selection of recommendations does not include the 19 Priority Recommendations that were endorsed by Conference delegates. Those that follow were generated by delegates to the Conference but are not necessarily endorsed by the NRHA, its Member Bodies or other organisations.

Accreditation

1. Governments and university accreditation boards should ensure that the quality of rural/remote academic staff is equal to that of other staff members teaching a specialty field. Previous rural experience is an enabler. Interprofessional education should be incorporated into teaching curricula in health disciplines and educators need specific time and resources dedicated to such activities.
2. Attributes and competencies relating to interprofessional practice should be a core requirement for the accreditation and registration of health profession courses, at both undergraduate and ongoing professional development levels.
3. As the burden of reporting and accreditation assessment grows for government funded health and community services, innovative solutions are emerging. Some health services face two separate accreditation systems because they have both GP and allied health programs. Aboriginal Community Controlled Health Services will routinely have to deal with this problem, as government encourages the services to engage with accreditation. Work should continue to make accreditation more efficient, more culturally responsive and more likely to lead to sustainable and integrated quality improvement.
4. Achievement in community engagement should be a mandatory requirement in accreditation processes for health services. EQUIP has criteria 1.6.1, 1.6.2, 1.6.3 which are around community engagement, patient rights and responsibility and special needs (CALD, Aboriginal, and Disability) but they are not mandatory criteria.
5. Country representatives should be involved in accreditation processes.

Aged care

6. Governments should support demonstration projects in aged care which focus on innovative and flexible service approaches in rural and remote areas. These approaches may include partnership arrangements with existing service providers and/or governments, with a renewed focus on healthy ageing and more equitable access to aged and community care services.
7. Funding for aged and community care in rural/remote areas should be reviewed to enable parity of wages between the public and private sector, and to attract staff to rural/remote areas.
8. In acknowledgement of higher dependency levels of residents in multipurpose services, and to reduce the gap between revenue and cost in the provision of residential aged care in rural areas, the Department of Health and Ageing should fund multipurpose services in such a way as provides them with parity with mainstream aged care providers.

Alcohol and health

9. A comprehensive national alcohol strategy should continue to be implemented in Australia and periodically evaluated.

10. Governments should ensure that policies relating to the consumption of alcohol should remain on the national agenda and make the reform agenda in the area an urgent priority.
11. Available evidence should be used to target and make more effective risk prevention interventions relating to alcohol consumption.

Arts in health

12. Art can play an effective role in stimulating action on access by and for people with a disability so that they can make a contribution to the community and its diverse and dynamic culture. Governments should recognise and generously support arts activities involving disabled people as positive pathways to supplement other supportive interventions promoting citizens' wellbeing.
13. Scientific evidence demonstrates that 'Arts and Health' is integral for preserving and enhancing health and wellbeing for individuals and communities. The health sector should develop partnerships with the arts and education sectors to facilitate policy development, practice and research in the field of Arts and Health. Also, Arts-in-Health practitioners should be accepted as professional specialists within multi-disciplinary health care teams.
14. Art is useful as a way of contributing to community healing post-disaster, and engendering healing, resilience and positive outcomes. This requires creative endeavours within a community to be well supported.
15. Rural health programs (including especially for child and adolescent trauma rehabilitation) should incorporate traditional rural pastimes and arts to build acceptance, worth, recovery and resilience in the communities involved.
16. Professional teams delivering health and community development should recognise that artists have highly developed technical skills which can be used to communicate with target audiences and provide them with tools and products which they find easy to use and effective.

Cancer care

17. Improving cancer service delivery in regional and rural areas requires a number of different models determined by geography and population spread in different States and Territories. The central principle of Regional Cancer Centres is now accepted, but issues of appropriate staffing levels and the interface with more distant communities need to be addressed urgently. There is increasing evidence of the benefits for patients and clinical staff of novel models of providing care such as telehealth and videoconferencing. More clarity is needed around funding of telehealth-based episodes of care. Long-term, sustainable funding of cancer care coordinator roles, with appropriate systems of support and education, is a key to appropriate regional cancer service delivery.
18. For small towns where travel by a medical oncologist is not time-efficient, videoconference clinics can be used to consult patients and to safely supervise chemotherapy at more regular intervals than four-weekly or more.
19. Attention has to be given to the importance of system-wide collaboration across regional and metropolitan cancer services.
20. The Cooma Oncology Unit has demonstrated its ability to provide a quality and safe rural oncology service for its local community. It can remain as a viable operational unit if it

can address staff training and succession planning, financial issues, and if patient numbers and Occasions of Service justify the continuation of the service. Aspects of this model could be transferred to other rural sites within NSW. If the NSW Cancer Institute is interested in developing other rural models of care, the Cooma model should be carefully considered for its strengths and weaknesses and how it can inform developments at other rural sites.

21. The RFDS skin cancer clinic outcomes demonstrate that patients can be reassured that their care is not being compromised by their geographical location. Further studies would assist in the future development of models for skin cancer clinics in remote areas.
22. Hospitals and health services should be aware of the high proportion of cancer professionals at risk of burnout and consider protective strategies such as screening, communications skills training and peer support.
23. There needs to be wider promotion of the availability of free, online educational programs about cancer care for nurses (EdCaN) and for GPs and primary health care professionals (EPICC).

Climate change

24. Health professionals should form a National Environmental Health Alliance to educate and advocate about the health impacts of climate change – possibly involving strategic alliances with well-funded organisations such as telecommunications providers.
25. Federal, state and local government planning for industrial and residential development needs to accommodate estimates of current and future water availability.
26. Federal and state government should provide financial incentives to support the development of local renewable energy supplies (eg wind, solar, sequestration, traditional land management), which should be seen as major economic opportunities for rural Australia.
27. Federal and state governments should provide 100 per cent subsidy or tax rebate for all households, and small and medium sized businesses, for installing wind or solar power generators. There should be no restrictions for households on the number of units installed. Design for new public housing should include such installations, with retrofitting of existing public housing.
28. The health service sector (including all levels of government and health service providers) should lead by example on climate change and be targeted for strategic use of innovation to reduce carbon emissions. For example, and as a matter of urgency, public infrastructure (eg hospitals) should lead with best practice renewable energy and efficiency design (eg for harvesting storm water).
29. There should be a national water body. Part of its charter would be to guarantee sufficient fit-for-purpose water as a right for every rural and urban Australian.
30. Responses to natural disasters should include initiatives to build community resilience.
31. Across Australia, environmental literacy needs to be regarded as equally important as broader literacy and numeracy for all ages. Departments of Education (State and Federal) must incorporate climate change education in university and school curricula.

32. The Federal Government should target any future incentives under the response to the GFC to adapting current infrastructure to mitigate climate change in an equitable socio-economic way.
33. Climate change must be recognised by all government agencies as a core issue for health, and its impact on health policy, planning and service delivery, and the need for proactive mitigation strategies, should be required in all health priorities and initiatives at national and state levels.
34. The Federal Government should accept responsibility for informing communities about the possible impacts of climate change in their region and for supporting communities to mobilise and develop culturally appropriate local solutions to address the threat.
35. Professional colleges and associations should raise awareness of the need for advocacy on the health effects of climate change amongst all health professionals.
36. The Australian Government should acknowledge that climate change is not only the most significant health challenge of the 21st Century, but puts the survival of humanity at risk. For this reason, it should make mitigation and adaptation a top priority for the whole of Government.
37. There is a need to develop regional understandings of the effect of climate change on health, and relate these within a national context to Australian medical education and the development of emerging clinical and non-clinical competencies.

Community participation

38. Local stakeholders, DoHA and FAHCSIA should collaborate in a *Community Based Rehabilitation Coalition*, and seek funding to support a pilot project. The pilot, involving stakeholders drawn from health, disability, federal, state and local governments, and non-government local community groups, would collaboratively develop a detailed plan, implementation strategy and evaluation process.
39. Local, state and federal governments should support long-term, methodologically sound research into the benefits of community participation in rural health settings. Communities should be supported to report and disseminate their own experiences of community participation. Health workers should be supported in policy and in practice to implement and evaluate genuine community participation.
40. Community advisory committees should engage key community stakeholders from the beginning to create a coordinated approach to health service provision in communities within a geographical region.
41. Communities and health authorities should develop health services that are based on an understanding of individual communities and their strengths, rather than designing services to meet needs or solve problems. To this end, there should be greater attention given to the development of tools for evaluating community strengths to assist in health planning.
42. State Government and individual managers and clinicians should support upskilling of staff in cultural awareness and community development practices. This would help enable the building of social capital and capacity, facilitating collective action in communities, and collaborating with communities to promote true participation and ownership of health,

with health professionals taking a consultative role at the request of an informed community.

43. State governments should give community members opportunity to be involved early in the process of developing a Multi-Purpose Service. Local managers should be released from their normal duties and supported to manage the process and involve the community effectively.
44. There should be support for the proposal in the interim NHHRC report for citizen juries on specific issues, and for them to include community, clinical and other key stakeholders. There should be opportunities for both random and formal selection of participants.
45. All Australian jurisdictions should develop legislation, based on the Victorian model, to facilitate the return of health service governance to boards that are truly connected to the community being served.
46. Health professionals and their employing bodies, government organisations and local councils should give greater emphasis to strategies to ensure rural and remote communities are able to benefit from government-initiated strategies such as the RTA Pedestrian Access Mobility Plan and Bike Plan programs. Greater involvement of health professionals in such programs may assist in the development of plans that address a greater range of factors and result in more wide-ranging benefits for communities.

Other consumer issues

47. Health service providers should ensure their workplace has a robust complaints handling process, fostering open disclosure of errors and a commitment to using complaints to improve services. Consumers should at every opportunity be encouraged to become actively involved in their health care and trained to raise concerns about health services in ways that respect the service providers and maximise the chances of better outcomes for patients.
48. Physiotherapists and health care workers must ensure that road trauma patients are well informed regarding the role of the health care workers, their injury status and the purpose of each treatment to improve patient compliance and, thus, recovery.

Diabetes

49. Tertiary diabetes clinics should promote the holistic rural model to assist in promoting better glycaemic control, improved patient satisfaction and better quality of life for rural children with diabetes and their families. Allied health Enhanced Primary Care (EPC) rebatable visits for Type 1 diabetes should be increased to 16 visits per year, in keeping with NH&MRC recommendations.
50. Credentialed mental health nurses should be eligible to receive MBS rebates for focused psychological strategies under Better Mental Health Outcomes, particularly in rural areas.
51. Paediatricians in rural areas should be able to generate EPC plans for children with diabetes in rural areas to facilitate the NH&MRC recommendations without further impacting upon the family.
52. Onsite HbA1C should be rebatable for rural children on a par with metropolitan child diabetes clinics.

53. Group consultations for patients with Type 1 diabetes should be equally eligible for rebate as for patients with Type 2 diabetes, who have lower complication risk.

Early childhood

54. Bodies providing funding for early childhood activities, and local Councils, should include field officers in early childhood health and education programs, and safe family friendly spaces should be made available or preserved in Council planning activities.

Early intervention

55. The Federal Department of Health and Ageing should continue to recognise the importance and value of Community Point of Care Early Intervention Health Checks conducted by nurse practitioners/practice nurses and trained health workers to support better health outcomes/compliance and referrals to doctors with supportive evidence for primary/chronic care and medication. Both men and women benefit from this process. Point of care testing allows for greater participation rates with results processed into client records for the doctor and allied health workers' follow-up/recalls.

E-health

56. The following considerations should be given to the introduction of e-health records:
- the implementation of e-health records should be undertaken using a consistent national framework;
 - all jurisdictions and relevant organisations shall endorse the early adoption of e-health patient records;
 - basic infrastructure and facilities should be fast-tracked to support the implementation of patient e-health (eg broadband);
 - implementation of e-health should recognise the need for expert and skilled support; and
 - expansion to include all aspects of healthcare agencies, eg Centrelink should be explored.
57. To help ensure access to Medicare for rural and remote clients, telehealth consultations throughout Australia should be supported by Medicare rebates.
58. There should be further development, trial and implementation of electronic connectivity between GPs, hospitals and AMSs initiated locally, enabled through a flexible approach to existing rules. Once developed and functional, it can be exported to metropolitan areas as a precursor to a national database.
59. The Australian Government's broadband initiative should be leveraged to provide state-of-the-art e-health infrastructure for rural Australia.
60. NEHTA and the Federal Government should ensure that the national e-health initiatives focus on systems that are inclusive of the multi-disciplinary team, rather than the current medical focus.
61. Public and private health service providers should actively consider broadening the use of telehealth and videoconferencing in the delivery of high quality health care, with the benefit of reducing fossil fuel usage for transport.

Environment

62. All providers of health care services should look for opportunities to reduce waste, reuse and recycle equipment where possible, and consider the environmental impact of procurement of goods and services.
63. Federal, state and local governments should facilitate simple strategies such as local composting to reduce emissions and provide fertiliser.
64. Professional Accreditation Bodies should incorporate principles of environmental sustainability into the accreditation standards of health care facilities and clinics.
65. All public and private health service providers should look for opportunities to co-locate facilities, especially daycare services, as part of an overall strategy to enable those using or involved in the service to minimise fossil fuel usage in travel.
66. Governments should invest in opportunities for local rural communities to develop sustainable practices such as recycling, not always readily available in smaller towns.
67. Health service providers should look for opportunities to develop local self sufficiency in the delivery of health care including ancillary services, for example laundry services, sourcing of local food and using health facility sites for food production.

Ethics

68. Because rural populations are at risk not only for clinically disparate care, but also ethically disparate care, there is a need to expand the focus on rural health care ethics and develop a rural ethics agenda by establishing a network for rural ethics (and possibly an Australian Centre for Rural Ethics) in order to enhance the scholarship, research, and teaching on rural health care ethics.

Expanded scopes of practice

69. A consortium of health services and Universities from rural Australia should develop a rural nurse practitioner framework inclusive of education, clinical internship and role development within the organisation.
70. With their history of clinical competence, emphasis on primary care and wide acceptance among doctors and patients, physician assistants (PAs) should be viewed as a valuable asset and can help to meet the world's current health workforce deficiencies. Much remains to be done before the implementation of PAs into Australian healthcare, not the least of which is to make absolutely certain that their training and utilisation in no way compromises the education of the new wave of medical students, displaces doctors from the workforce or usurps their authority. The flexible, locally negotiated PA scope of practice and collaborative relationship with the health care team make PAs ideal candidates to serve in areas of critical need. The introduction of physician assistants may be one strategy for addressing the medical workforce shortage in Australia.
71. Governments should ensure that physician assistants are available across all medical services in rural and remote areas, but they should not be used for 'plugging' shortages of doctors in rural and remote areas.
72. Nurse practitioners and physician assistants should be promoted equally, and there should be an emphasis on 'grow-your-own' models. The approach should be to "delegate to

strengths; teach to weaknesses”. Clinical space configurations for new team practice models need to be considered.

73. Ambulance officers and paramedics should have access to ‘save my life’ data to facilitate patient care.
74. The Australian Government should consider national regulation, accreditation and registration of paramedics.
75. Formal education should be available for the rural/remote paramedic specialty, in order to better prepare paramedics who aim to work in such localities for the unique demands of paramedic practice there.
76. State, Territory and Commonwealth governments and health care providers should recognise the valuable contribution that ambulance services can make to rural and remote communities by providing an option for a wider range of primary health care and health prevention services as part of integrated health care.
77. At least the first year’s training in the health science aspects of undergraduate health professions should be undertaken collaboratively.
78. Governments should fund the development of expanded role initiatives that link ambulance and other health care services to provide integrated health care options for rural and remote communities.
79. Governments should fund increased opportunities for paramedic students to undertake at least some of their training in a rural setting, including through support for rural placements and for rural paramedic students to stay in their own communities.
80. Paramedics should be recognised by governments as allied health professionals.
81. Extended care paramedic training should include awareness of the needs of palliative care patients, including in relation to advanced care plans. Their education should cover pain management and palliative care emergencies, as well as resuscitation.
82. It should be recognised that rural paramedic practice is different from urban paramedic practice in that the rural paramedic is a highly involved and visible member of the community, working closely with other health professionals and ambulance volunteers. With these differences, the rural paramedic is involved with community involvement, multidisciplinary awareness, an awareness of volunteers, and professional accountability. Rural clinical placement for paramedic undergraduates, or courses with a multidisciplinary focus, will benefit not only the paramedics but also the health needs of rural communities in which they practice.
83. The Ambulance Integration Project in rural NSW should be rolled out to additional sites, with sites establishing specific goals and activities that meet the needs of their communities and fit within the interest and skill level of the participating paramedics and health staff. Local GPs need to be included in the decision making around chosen activities and appropriate protocols to be followed, whether in an emergency department (ED) or Community Health. In ED, consistent protocols need to be established across all sites so that ambulance paramedics fully understand what activities they are authorised to do while supporting the health staff. Training programs to upskill all participants need to be established and regularly delivered at all sites.

Eye health

84. To help close the gap in eye care between rural and remote Australia, Schools of Optometry should increase their intake of undergraduates from rural areas, from States without optometry schools and States with high proportions of Indigenous people. Bonded scholarships should be provided by rural health organisations and State Governments that do not have Schools of Optometry - or, alternatively, HECS reimbursements for rural and remote service by optometry graduates, weighted by remoteness.
85. Locum relief is required by most optometrists in rural and remote areas. Overseas trained optometrists on temporary visas could be used to service rural and remote areas if Australian registered locum sources were unable to meet the need.
86. The Commonwealth Government should give financial support for optometrists who travel to RRMA 6 and 7, or other areas of need, with the optometry Medicare rebate weighted by RRMA factor.
87. State Governments should allow optometrists to work in rural hospitals, so 'hub and spoke' models of practice can be established in RRMA 6 and 7. Policy makers should be aware that the increasing proportion of women in the optometry workforce will mean there is a corresponding reduction in the number of rural optometrists.

Health education

88. The Australian Government, professional bodies and Universities should establish a centre for excellence for interprofessional learning to lead the national agenda and structure it for rural areas to take the lead, as they are so well placed to do.
89. There needs to be greater collaboration between the NRHSN and Universities to streamline activities designed to stimulate interest in rural/remote practice and maximise their impact.
90. Interprofessional rural health education should be a core part of undergraduate health science curricula.
91. The online clinical educator preparation program should be made available nationally to health professionals from a variety of disciplines, and support given to those wishing to access the program. The online program should have online moderators to promote contact and the ability of participants to complete. The Australian Rural Health Education Network and the individual University Departments of Rural Health should support the implementation of the program for all rural health professionals acting as clinical educators.
92. There is a need to reiterate the importance of the remote health practice manuals to remind funders and developers that these are resource-intensive and require funding.
93. Commonwealth and State Governments, and Colleges of medicine, allied health and nursing, should ensure that new graduates have access to programs that prepare them for rural practice. These programs should be multi-disciplinary in format, utilising existing services such as those offered through the specialist medical colleges.
94. The need for locally initiated and developed health education resources that are appropriate to individual communities is critical for Aboriginal and Torres Strait Islander

communities. The process of resource development provides a forum for education, as does the end product.

95. University admissions to the schools of optometry (UNSW, QUT and MelbUni) should be based not just on TER score, but on a demographic match that reflects Australia's society; that is: 50 per cent male; 30 per cent of rural origin; 3 per cent Indigenous; 10 per cent of places reserved for Western Australian or South Australian students.

HIV

96. An effective model of care for HIV positive people in Australia needs to be supported by an expansion of multidisciplinary teams that are patient-centred and integrated to provide comprehensive care, particularly for complex (and chronic) conditions. This requires the reallocation of responsibilities so that service delivery mechanisms match the level of specialist/generalist care needed on a case-by-case or casemix basis.

Indigenous health

97. There needs to be greater support and investment in building the formal evidence and theory base underpinning our understanding of the changing face of 'community' in the 21st Century, and exploring new opportunities. Local research on these should inform undergraduate Indigenous health training.
98. There should be Indigenous knowledge transfer to mainstream mental health workers about Indigenous experience and concepts of mental health (i.e. approach to helping the 'inner soul').
99. All cardiac facilities should employ and support the professional development of Aboriginal and Torres Strait Islander Health Workers as part of the cardiology team. In the case of multiple service providers for a community or facility there must be Memorandums of Understanding which are reviewed annually by the Executive Management of both/all parties with reportable indicators for cardiac rehabilitation. There should be bi-annual cardiac rehabilitation training of multi-disciplinary service providers in Indigenous communities.
100. State governments, professional associations, health professionals and consumers should promote Aboriginal health literacy and the capacity for self-management of health conditions.
101. An expert working party should convene to identify a standardised map of the processes required for a sustainable Cardiac Rehabilitation Service in Indigenous communities, with corresponding performance measures for the monitoring of the implementation of the process. There should be tools and resources to help with the implementation of cardiac rehabilitation processes, and medical discharge summaries for patients being transferred or discharged from tertiary healthcare facilities with cardiac disease should have a mechanism triggering routine referral of the person to Cardiac Rehabilitation.
102. There should be a reorientation by all health services and individual providers to the principles of Comprehensive Primary Health Care. Health services and providers should actively seek to create a body of knowledge of contemporary Indigenous health knowledges, beliefs and practices, and implement this knowledge in practice.
103. *Kids Pitstop* [Roebourne, Western Australia] is a new and constantly evolving health 'one stop shop' for Indigenous children and their families. It offers families a variety of

nursing, allied health and other professionals in the one location, on the one day, once a month with a flexible model of service delivery in a relaxed family orientated atmosphere.

104. State/Territory Health Departments should fund and support Indigenous young mums' support groups facilitated by dedicated Indigenous health workers.
105. There needs to be greater recognition of the place of traditional healing in a comprehensive primary health care approach to the health of Aboriginal and Torres Strait Islander populations.
106. The National Health and Hospitals Reform Commission should ensure that its recommendations for Indigenous health are ones that will empower Indigenous communities.
107. The Federal Government should extend support for the accreditation of Aboriginal community controlled health organisations.
108. In order to address the critically poor oral health being experienced by Indigenous Australians and the fundamental lack of oral health care within primary health care services, all Indigenous medical services should receive sufficient infrastructure and operational funding to provide, firstly, lifelong (from infancy to old age) oral health screening, education and preventative care within routine health checks and, secondly, regular preventative oral health care professionally delivered to all community members by dentists and/or oral health therapists based on standardised individual need and risk assessment procedures. Aboriginal communities and health workers should have a key role in the development, management and delivery of the new oral health care services.
109. Government should deliver on its promise to restore the Racial Discrimination Act in the Northern Territory.
110. Government should increase broad-based investment in the social determinants of health for Indigenous communities, such as proper schools, teachers, housing and policing, both in the Northern Territory and nationally.
111. The NT Emergency Response has resulted in the development of stronger partnerships between the Commonwealth, the Territory and the Aboriginal Community Controlled Health sector. This partnership needs to be confirmed, extended and resourced throughout Australia.
112. There needs to be a properly resourced national framework for health services across Australia which ensures that everyone, including Aboriginal and Torres Strait Islander peoples, have a real say in the policy and services which affect their lives. The notion that decisions should be taken as closely as possible to the people affected should be an operating principle in designing such a framework.
113. There should be mandatory cultural safety training for any health practitioner who begins work within state and federal health services, with a key focus on the impact of worldviews and Indigenous health issues.
114. There need to be increased tertiary education resources to help in the teaching of culturally competent allied health professionals.

115. All public and private health agencies and professional bodies should recognise the need for professional competencies that reflect the need for culturally safe practice.
116. The Australian Government should provide national funding to support Aboriginal Health Workers to attend the biennial National Rural Health Conferences, with such support recognised as part of workforce development.
117. This conference recognises the benefits of ‘bulletproofing’ and resilience building activities for Indigenous health students and staff, and encourages further exploration of this concept at policy, training and health service levels. In parallel with existing cross-cultural training and other anti-racism measures, health-related policy and health service delivery and training organisations should implement activities that promote resilience building among Indigenous health students and staff.
118. Efforts to improve the health of Aboriginal people must be based on holistic, intersectoral collaboration between health, education, economic, public, private, and non-government sectors. Efforts must be strategic and long-term, whereby each stakeholder contributes completely, while refraining from assuming control and ownership over Aboriginal communities’ contributions, ideals and preferences.
119. The Mapping Aboriginal Health Partnerships (MAHPET) project demonstrates the conditions for success of an action research process using network mapping when difficult discussions are required to deal with issues that are ‘put on the table’.
120. State governments, professional associations, health professionals and consumers should make additional efforts to encourage and enable mainstream health services to provide culturally-appropriate and empowering healthcare to Aboriginal and Torres Strait Islander people.

- ***Indigenous health (NTER)***

121. Positive aspects of the NT Emergency Response, particularly the Enhanced Health Service Delivery Initiative [Phase 3 of the Emergency Response which involves the roll out of regional health board reforms and the work of the Remote Area Health Corps], support of community control, proper per capita funding of comprehensive primary health care, regionalisation and local control of pooled funds, should be rolled out in collaboration with the community controlled health sector and Aboriginal peak bodies across all rural and remote Indigenous Australia.
122. Among the lessons learned from the Northern Territory intervention, the government should recognise that the intervention ran counter to a primary recommendation in the *Little Children are sacred* report that empowerment should be an important component in the solution to community issues.
123. Changes to the Community Development Employment Program (CDEP) can affect the social gradients of health. The provision of alternate full time employment is a positive, but abolition of CDEP needs to be managed in a way that ensures it does not further disempower communities and add to health risks.
124. Such disempowerment of Aboriginal people living in remote communities as resulted from the NT Emergency Response must never be repeated again. It was based on a report by those who visited only 45 of the 80 communities ‘taken control of’ and portrayed Aboriginal men as child molesters, which could have the effect of increasing cases of suicide, depression and related illnesses.

125. Preliminary results for the NT Intervention in regard to the *Little children are sacred* report suggested that there were hundreds of children being abused. The interim review showed that there had been only four convictions for child (sexual) abuse.
126. Based on findings to date, the NT intervention should not continue – or it should be introduced to non-Indigenous Australians since child abuse is common in white society.

- ***Indigenous health (smoking cessation)***

127. Culturally sensitive, evidence-based smoking cessation programs should be made available to Aboriginal communities and all Indigenous smokers. They should be comprehensive and sustainable – not just brief interventions. They need to acknowledge individual, household and community factors driving the high rates of smoking in Indigenous populations, and address psychosocial and historical elements of trauma and current stress. These programs must be well-resourced. Pregnant women (and their families) should be given highest priority in such programs.
128. Research into effective smoking cessation strategies for Indigenous smokers is essential to help close the gap in Indigenous health. Research bodies and state government bodies should consider Action-Research as a model to create local evidence to inform anti-smoking initiatives in remote communities.
129. It is critical that local Aboriginal health staff are provided with training and skills to support the community in its work to a change smoking behaviours.
130. Aboriginal Community Controlled Health Services, with adequate training, support and funding, are ideally placed to run smoking cessation programs such as Give Up The Smokes (GUTS).
131. Following the success of the Give Up The Smokes (GUTS) course, others aiming to develop culturally-appropriate smoking cessation courses should include evidence-based approaches, discussion about the Indigenous history of tobacco use, targeted information about prevalence of smoking and the health and other effects of smoking in Indigenous smokers. The program should have a high level of interactive and visually stimulating activities. Exploration of women's views on smoking allows a greater understanding of both the reasons for continued smoking and the complex array of factors affecting behaviour.

Infrastructure

132. Those at the 10th National Rural Health Conference challenge State/Territory and Commonwealth Governments to urgently address infrastructure and accommodation deficiencies in remote communities.
133. The development of accommodation infrastructure is vital for permanent staff in rural and remote communities, and should also be provided for health staff required to stay for shorter periods.
134. There needs to be further intersectoral collaboration to design, build and maintain walkways, bike paths and other health-promoting infrastructure in rural and remote communities.

International issues

135. The Australian Government should ensure that working migrants are entitled to social security, medical services and medical benefits (MBS).
136. State government programs currently in place for supporting Overseas Trained Doctors should be expanded to include bicultural challenges in rural, regional and remote localities for overseas-born Australian-trained health professionals.
137. Health science courses in Australian Universities should give greater consideration to the acculturation needs of overseas-born Australian-trained health professionals that arise when they make the transition to work in rural communities.

Leadership

138. The Australian Government should fund the development of a Health Leaders Program based on learning how to be an effective leader, rather than manager.
139. There should be greater national attention given to leadership training for consumers, advocates, community members and health professionals.
140. State and Territory Governments should provide clinical leadership courses for allied health staff.

Maternity services

141. It should be recognised that the lack of specific policy in rural maternity care has a constraining effect on government action in this area. While rural birthing services continue to close, the policy goal of equitable access to care is not being achieved. The centralisation of services which results from rural maternity unit closures has given rise to a number of financial, personal and social barriers to rural residents' access to care.
142. The Australian Government should establish a National Maternity Health Centre to lead the process of improving maternal/pregnancy outcomes by translation of evidence into practice – particularly clinical practice, consumer information and models of caring. The body should be modelled on the National Breast and Ovarian Cancer Centre. It would use evidence and consensus to achieve nationally-agreed resources and models for shared antenatal care, for example, and guidance for practitioners. This would significantly improve on the current situation in which there is a plethora of such resources developed by different hospitals and maternity units.
143. Scholarships should be offered for midwives to undertake education for MBS and PBS accreditation.
144. The development of rural maternity services should be on the basis of evidence, including about the needs of individual communities.
145. Any proposal to downgrade or close a rural maternity service should include a current social impact statement and analysis of the social and economic risks attached to closure or downgrading.
146. The Government should act on the proposals in the recent maternity services review for the development of collaborative care guidelines by rural paediatricians, midwives and GP and specialist obstetricians.

Men's health

147. The health industry should become more familiar with the Men's Sheds concept and governments should provide funding for larger, more robust and sustainable community men's sheds as a legitimate avenue for the provision of primary health care services for Indigenous men.
148. There should be a national longitudinal study of men's health, to compliment the women's study. It should include a specific rural cohort and would throw some light on the associations between biological, psychological, social and environmental impacts on health.
149. Men's Sheds should be recognised in national and state health policy as an important and legitimate primary health care initiative to address the social and emotional wellbeing and other health determinants of men, and this policy recognition should be accompanied by appropriate funding and other support.

Mental health

150. Mental health services, research and education institutions (e.g. ACRRM, RACGP) should develop models of service which are specific to the cultural and social constructs of rural people. There should be capacity building within the community, and the identification of depressive illness in the community should not be restricted to health care professionals.
151. Funding is needed for the development and/or purchase of a range of supported accommodation for people with a mental illness in rural and regional areas, and for support services including personal support, community access, education and training.
152. Strategies to improve mental health should include:
 - routine screening for mental health problems in secondary school (eg this could be internet based with students completing a six module moodgym assessment);
 - further extending prevention programs in areas where access is difficult by e.g. internet based intervention;
 - early intervention for mental health problems on a rural school campus to increase access and combat social visibility/confidentiality issues (e.g. doctor's surgery could be in a neutral consulting area such as the school counsellor's office);
 - improved training for school counsellors to increase competence in dealing with mental health issues in young people;
 - improved training for GPs in adolescent mental health;
 - financial incentives to reimburse GPs to allow for increased time commitment in dealing with adolescent mental health;
 - capacity for rural and remote school counsellors to refer directly to psychologists (if there are access issues, teleconferencing should be considered) for assessment if standardised screening tests show a high rate of mental distress and if access to health professionals is difficult; and
 - teleconferencing with psychologists for cognitive behaviour therapy under the Better Outcomes in Mental Health Initiative in areas where access is difficult.
153. The Centres for Rural and Remote Mental Health should:
 - continue to emphasise - and to influence governments to understand - that it is essential to link and coordinate local services related to drought and mental health;
 - work out ways to 'package' a disaster-scenario reality about climate change and drying in a way that is realistic but not overwhelming, and to help identify constructive pathways to workable solutions;

- further develop ways to (i) encourage one-stop shops, especially mobile versions (eg buses) and (ii) advise on how to get people to visit the buses - eg, by having multiple non-health/wellbeing-related services included with drought mental health and related services - mental health cannot always be the public face of service provision, but can be tagged 'invisibly' onto more 'acceptable' services;
 - ensure funders and governments understand that all workers in the mental health field in rural areas need to understand the local industries; for example, if they are not from a farming background but work in a farming area, they need training;
 - promote the integration of primary health care and related services with respect to the health impacts of drought and climate change; and
 - promote a 'pearl in the oyster' approach to climate change - with climate change seen as an opportunity to use a strengths-based approach to community capacity building and, therefore, mental health improvement.
154. State Departments of Health should base rural and remote mental health policies and services on fine-grain analyses of local needs, to allow for community individuality and ensuring there is a social model, in preference to a medical model.
155. Australian and State/Territory Governments should fund mental first aid training in a farm context for community health and mental health workers who have contact with a farm clientele.
156. To promote their access to counselling and health services, data profiling should be incorporated into service planning for farm clients.
157. FAHCSIA should provide additional funding for transitional accommodation for people with a mental illness as an alternative to hospitalisation (and homelessness) in regional locations.
158. FAHCSIA should provide funding to support parents of adult children with a mental illness to develop future strategies for their accommodation and care.
159. Professional associations, Australian and State/Territory Governments should develop a tool to act as a prompt list for GPs in rural and remote areas to recognise masked symptoms of depression in men.

Mentoring

160. Rural Clinical Schools, State Health Departments and Regional Health Services should ensure that preceptor tools and training are made available to clinicians supervising students. The experience should be 'learner-focussed' and the tools and processes used should make the experience easier and more efficient both for the student and clinician. Funding needs to be available for both the clinicians and administrative personnel to help involve students in the community.
161. Local governments should develop an intra-professional mentoring stream, including non-health professionals, so they can develop common capabilities and resources.
162. Government, professional organisations and universities must recognise the need for rural practitioners to be involved in teaching and hosting placements.

Movement health

163. There is an emphasis on Medical, Mental, Maternity and Men's Health. We need to add to the lexicon 'Movement Health' to drive funding for multidisciplinary initiatives increasing health and wellbeing through the professions that promote and improve movement, such as the podiatrist, physiotherapist, dietician and OT.

National Rural Health Conferences

164. Future conference dinners should not serve alcohol at the table and ought instead try to encourage culture change by selling alcohol at a bar if required and at personal cost.
165. More should be done to promote careers in health to rural and remote primary and high school students, and national forums such as the National Rural Health Conferences can play a role in this. Encouraging more rural health professionals to act as mentors would assist with this.

NRHA (governance and management)

166. Given the importance of the social determinants of health, the NRHA should include within its membership groups such as farmer and teacher organisations and others that influence the social, economic and cultural aspects of the rural environment.
167. Membership of the NRHA should be expanded to include peak rural and remote 'health consumer' bodies such as National Farmers' Federation, Minerals Council and the Australian Local Government Association. At present it is top heavy with 'health' representatives.
168. The Australian Journal of Rural Health (AJRH) is currently (up to end of 2008) the journal with the highest number of rural and remote health publications in PubMed. The AJRH displaced the American Journal of Rural Health from this position in 2007. The NRHA and the professional organisations which support the journal should work to ensure its business sustainability.

NRHA (policy and advocacy)

169. The NRHA should work with other organisations to develop a strategy for promoting to relevant Commonwealth Ministries the value of arts-in-health (see Minister Garrett's "Creative partnerships initiatives"), for building the evidence base for arts-in-health, and coordinating funding for arts-in-health.
170. The NRHA should develop a position paper on arts-in-health, supporting the placing of arts at the core of health promotion, in community engagement in the analysis and planning of health services and supportive community activities, and in specific health issues such as mental health, oncology, pain management, rehabilitation and crisis response.
171. The NRHA should argue for global health equity as well as equity within Australia.
172. The NRHA should form a working group to develop an action plan, in collaboration with non-health professions, to improve attraction, retention and welfare for rural professions of all types.
173. The NRHA should encourage the Australian Government to fundamentally reform undergraduate student selection, training, placements and continuing professional

education in order to refocus health system practices and individual practitioners on delivering interdisciplinary team-based person- and community-centred empowering health care.

174. There should be greater focus on promoting careers in health to rural and remote primary and high school students, including at national forums such as the National Rural Health Conferences. Having health professional mentors in rural communities would go a long way to encourage students to pursue a health career. In Queensland, the Health Career in the Bush program engages rural health club members to conduct rural school visits and much more could be done in this area to encourage school students to consider this pathway.
175. Health professions and governments should combine with academic institutions to understand and overcome the professional development, and personal and emotional support challenges which currently affect all professionals working in rural and remote areas.
176. There should be greater emphasis and support for quality rather than quantity of the health workforce in remote Australia through increased education (postgraduate, continuing education of remote workforce), increased requirements for continuing education (eg CNE points for remote area nurses or RANs), credentialling of RANs, set standards for remote clinics and for remote health services on employment, education and support of staff.
177. The National Rural Health Alliance should continue to work in partnership with ADCA and State peak bodies working to promote responsible drinking in the community.
178. The NRHA should develop and publicise best practice guidelines for when a community decides to change its drinking habits or practices.
179. The experiences and knowledge from Fitzroy Valley Alcohol and other Drug Management Committee should be shared throughout the National Rural Health Alliance network to benefit other communities.
180. The NRHA should produce a fact sheet regarding guidelines for community engagement to ensure that services offered (eg by RFDS) are what local people require.
181. The NRHA should identify the highest priority needs for telehealth development in rural health care and develop an action plan.
182. The NRHA should support a national conference dedicated to climate change and health.
183. The National Rural Health Alliance should refer to ACRRM and the RACGP a request that those Colleges develop statements of the competencies that will be needed by doctors in a climate-changing world, with a view to incorporating appropriate elements of these into future curriculum documents and related quality assurance mechanisms.
184. The NRHA should refer to the Australian Government a request for funding for urgent work to prepare Australia's general practitioners for a climate-changing Australia, to be shared at the local, national and global levels.
185. The NRHA can help convince traffic authorities and local councils of the importance of pedestrian infrastructure for health, as well as a means of transport.

186. The NRHA should play a role in advocating for better oral health for all Australians.

Oral health

187. In recognition of the importance of maintaining good oral health and the negative impacts of oral disease and other oral conditions, there is a need for:
- incorporation of oral health care in primary health care service delivery models (rather than being segregated) and for future reforms to address this need as a high priority;
 - inclusion of oral health care within routine primary health checks, including screening, education and preventive care, and acute care when necessary;
 - provision of oral health care to Indigenous communities nationally as a high priority, with Indigenous Health Workers to play a key role in development, management and delivery of these oral health services in their communities;
 - inclusion of education regarding the impact of oral health within a primary health care context in all health profession education and training;
 - consideration of oral health as a high priority for the National Preventative Health Taskforce; and
 - GP Superclinics to involve the training and placement of oral health students and the co-location of oral health professionals to ensure that oral health is embedded within primary health care.
188. Oral health promotion information should be provided to mental health service clients. Education and training for general practitioners, community mental health care nurses and workers and allied health professionals should be provided to ensure a good understanding of oral health issues. Training for dental professionals in managing mental health clients should be a priority. Formal pathways for communication and referral between health care workers and dental services should be established.

Patient assisted travel

189. Priorities in improving patient travel and accommodation support include:
- increasing allowances to reflect the real costs, streamline form-filling for GPs, specialists and consumers;
 - providing clear, consistent information about entitlements; and
 - enhancing dependent and carer eligibility.
- When managed accommodation is not available at the hospital, timely information about alternatives is critical. There should be a registry of family-style accommodation near all major urban hospitals, and purpose-built family accommodation. There should also be increased financial support for community transport, support for volunteer drivers and guaranteed places for carers in air ambulance travel.
190. State Governments should provide coordinated support for the ‘whole-of-journey’ experience of rural health consumers, from the moment their GP refers them away, to their return home after treatment.
191. State/Territory and Federal Governments are urged to implement as a matter of urgency the recommendations of the Senate Inquiry into Patient Assisted Transport Schemes. [Note: four recommendations to this effect.]
192. The Australian Government should fully inform all patients eligible for PATS about the services and reimbursements available to them.
193. Health Consumers of Rural and Remote Australia (HCRRA) should work for PATS eligibility criteria to be made more flexible so as to include rural patients who need to

access services only available in regional centres inside the 50 km boundary and taking into consideration public transport availability and timetabling.

194. Governments should acknowledge that patient and family accommodation is a core element of health services, including at hospitals. This would mean that families from remote and rural locations who need to travel to access health care would be able to access low cost, comfortable, family friendly accommodation close to the health care provided.

People with disability

195. Closer attention should be paid to the health needs of people with lifelong disabilities, including their access to dental services. Funding for supported accommodation should be available in the rural towns in which people with disabilities and/or their family members reside, to enable retirement and ageing in place.

Pharmacy

196. There should be continued support for outreach pharmacists providing service to remote communities.

Primary health care

197. There should be increased government commitment to development and sustainability of primary health care programs, for example through the provision of sustainable program funding.
198. The National Health and Hospitals Reform Commission's recommendation regarding uniform Commonwealth management of primary health care should incorporate both the structural understanding of successful primary health care models (John Wakerman et al) and the Appreciative Inquiry method (as outlined by Joshua Tepper).
199. Health services should be reoriented to adhere to the principles of comprehensive primary health care. Health organisations should create and maintain a body of Indigenous health knowledge and practice, with these used in staff training and to promote ongoing refinement in clinical practice. Racism should be recognised and addressed as a primary social determinant of Indigenous disease, illness and dysfunction.

Public transport

200. Governments need to invest in better public transport in rural areas to allow more exercise and less use of cars.
201. State and local governments should provide increased access to public transport and carpooling, especially in rural and regional areas.

Reform of health system

202. All health service Boards of Management should include a medical practitioner, nurse and allied health representative to enrich and empower those boards with expertise that is currently not available in the models of some States.
203. To ensure success of primary health care services, there should be a single level of government responsible for management (i.e. Commonwealth or State).
204. The Australian and State/Territory Governments must collaborate to ensure that no Australian living in rural or remote Australia should have to pay more for health services (medical, specialist, dental or allied health) than a person living in urban Australia.

205. Area Health Service Boards of Management should again be given the authority to direct community health needs without fear or retribution from government if the chosen direction is at variance with regional health department strategy.
206. The Australian Government should ensure that the current reviews of health and hospitals, primary health care, and prevention lead to significant health care reforms and the end of the blame game between Commonwealth and States in the delivery of primary health care.
207. Australia needs to act on the ideas in Joshua Tepper's keynote address and create a conscious, fundamental change agenda; develop leadership for the new health system; use Appreciative Inquiry to foster creative and diverse solutions to old problems; put value for the patient in the centre of the system; and pay attention to mind, heart and body.
208. It needs to be understood that nothing will change in the health system unless there are changes to the way health is funded. It is time to stop the bickering, blaming and cost shifting: the Federal Government should take over the health budget entirely.
209. The Australian Government should give consideration to including 'rurality' in Medicare to enable the full reimbursement of costs of travel and accommodation associated with travelling to access health services.
210. Given that Australia is in the throes of health reform, including the development of a national primary health care strategy, now is an appropriate time to explore more flexible payment mechanisms for general practitioners and other health professionals. Australia has concentrated on influencing the behaviour of doctors through a range of incentives and programs rather than looking more broadly at how the health system is funded. This has had serious implications for access and equity for some of our most disadvantaged population groups, whilst at the same time ensuring fragmentation of service delivery between Commonwealth and state-funded programs.

Research

211. Further research is required to track the farm client's pathway into health care, and between members of the community health team.
212. Research organisations, state and local governments should increase the focus on older motorcycle riders, including 'returned' and returning riders, in terms of (1) research and (2) intervention development and implementation. The primary target area within north Queensland should be the Far North/Cairns region.
213. There should be funding to ensure rigorous and comprehensive evaluation of rural health services and the dissemination of findings, to ensure effective rural health policy.
214. The Australian Government, State/Territory Governments, partner organisations (i.e. NAPWA, ARCSHS, AHOD, ACON) and consumers should collaborate on a series of demonstration projects to gather evidence and information and test hypotheses about aspects of clinical service delivery and the future. The proposals would build on work that is already underway in some areas (and therefore funded) or work that has been identified as requiring development.
 - Explore mechanisms for facilitating and delivering shared care in the community
 - Develop and implement a series of tailored supportive solutions to support individual high caseload community practices to address workforce retention, recruitment, training and succession.

- Explore, implement and evaluate a range of nurse-based strategies aimed at increasing access to clinical service delivery.
Such proposals should be included in the next National HIV strategy.
215. Professional health bodies and governments should commence retrospective studies to determine the effectiveness of multidisciplinary training in emergency services in the local community. Skills training should be available within the local community to help maintain the health emergency skills sets specific to a community's needs.
 216. There should be clearer pathways for ethics clearance for health programs and research with school aged children.
 217. The NHMRC should provide additional funding for ethnographic and qualitative studies that will provide a better understanding of the spatial, social and environmental motivators that lead to a person choosing to live and work in a particular place. This would be the basis for a greater degree of sophistication in recruitment and retention programs.
 218. To provide a comprehensive database for evaluation of health status and service (and thus for a more appropriate allocation of health resources), there should be a stronger focus on funding data collection and data linkage.
 219. Acknowledging what we need to know now, and predicting our information needs in the future, is critical for the ongoing renewal of Australia's information infrastructure. Knowing what we don't know is also useful. There needs to be a coordinated and multi-stakeholder review of the current information needs of the rural health sector and an assessment of the Rural Health Information Framework's capacity to meet these.
 220. The Australian Institute of Health and Welfare, in conjunction with stakeholders, should conduct a coordinated and multi-stakeholder review of the current information needs of the rural health sector, including an assessment of the capacity of the Rural Health Information Framework to meet these needs.
 221. There should be a national study to ascertain the costs of welfare dependence and associated dysfunction.
 222. There should be continuous monitoring and evaluation of student support programs, and the findings should inform the adaptation of these programs to meet the needs of participants.
 223. Scope exists for further studies into the 'qualitative' aspects of graduates who end up practising in rural locations (i.e. beyond quantitative outcomes) to investigate the quality, training and credentials of rural practitioners.
 224. The Australian Government and individual health providers should continue to improve access to evidence-based practice for rural and remote practitioners (eg free online access via Australian Indigenous HealthInfoNet).
 225. Local employers and Area Health Services should use exit surveys for all rural health workers to better understand why people leave rural locations and professions.

Rural services and resources

226. State governments should be required to provide a rural Impact Statement for changes to rural services, with the assessment including the costs to the community (financial, safety, equity and access).
227. Creators of clinical guidelines can ensure they are on the right page and thus improve uptake and return on their investment by using a knowledge based practice approach considering both the evidence and the context, and by involving the end users in guideline development and review.
228. All associations, private, state and federal government organisations should provide health information and resources which are suitable for the rural and remote context taking into account:
- recognition of features of the remote context, eg distance to services;
 - the need for cultural suitability; and
 - that it is appropriately contextualised.
229. Commonwealth, State and Territory Governments should consider the extent to which the existing structures of government prevent regional and remote people from having a real voice in the decisions, policies and administration which affect their lives.

Schools and health

230. Federal and State/Territory Health and Education Departments should develop strong partnerships and collaboration between primary health care and education at both policy and operational level in the schools.
231. State Departments of Health and Education should provide career development programs at both primary and secondary school levels.
232. Life skills and social and emotional learning should be part of the core school curriculum, as these will act as protective factors for mental health, and facilitating factors for academic achievement.
233. The 2009 Federal Budget has significantly disadvantaged rural people trying to access Youth Allowance to support tertiary studies and living away from home expenses. Unskilled school leavers cannot get 30 hours per week paid work, especially in small towns and more remote areas. As a result, modestly paid rural professionals will leave rural/regional locations to move to the city for education for their kids.
234. Funding for the Wellington program should be continued and increased to support further program expansion and it should remain under an auspicing body independent of government and individual schools. The program should be expanded to schools in Coonamble, Brewarrina, Walgett and Broken Hill as these towns are in the 10 most disadvantaged communities in NSW. The program should incorporate Years 8 and 9 where a high risk of disengagement is identified.
235. A health screening program should be conducted at least once during a school's secondary education.
236. There needs to be work to explore ways to address the 'concealed' homelessness that is undermining students' progress in school.

237. Broad-based ‘sex positive’ sexuality and relationships education should be a mandated part of the education curriculum, in small group single sex sessions yearly from Year 8. Peer education may be a useful element.
238. NAP and PS NAPP are critical components in the development of comprehensive nursing career pipelines that provide the foundation for developing parental capacity and health career aspirations in school age children. The responsiveness of these programs to local and regional resources and partnerships enhances model adaptability and transferability to other settings and potentially other career pathways. The investment in rural and remote students from kindergarten to Year 12 and the additional investment in providing parents with the relevant knowledge and resources to enhance their ability to promote health careers to their children is critical.
239. There should be increased access to contraception, STI testing and abortion for young people in and out of schools, possibly through expanding the role of School Based Nurses.
240. Primary health care nurses need to be employed in schools.

Social determinants

241. The Australian and State/Territory Governments and the National Health and Hospitals Reform Commission should allow the social determinants of health to underwrite the opportunity to reform primary care health systems, and joined-up government mechanisms must be developed to enable ‘the dots to be joined’.
242. There should be continued development of partnerships between NACCHO and the Australian Government as a means of addressing some of the social determinants of health.
243. The Australian Government needs to develop policy that seriously addresses the social determinants of health (as per the WHO Commission). In particular, the empowerment of rural communities is of paramount importance, with well-established links between a community’s ‘sense of control’ and its health status.
244. The Australian Government should establish a new ministerial portfolio, the Office of Rural Development. It would cover all rural areas in Australia and encompass health, education, primary industry, housing, Aboriginal and Torres Strait Islander affairs, the environment etc. – and work across disciplines and government sectors.
245. Considering the impact of the social determinants of rural and remote communities on mental health, the Australian, State and Territory Governments should prioritise funding for early intervention support programs for primary school aged children and their families. Policy and planning should:
- foster partnerships between the education sector (government, independent and Catholic), the health sector (government and community controlled), and the community services sector (Government and non-government);
 - allow for engagement with communities to provide culturally and locally relevant support/programs;
 - ensure services are provided to children and families accessing long distance education; and
 - identify appropriate referral pathways and support when more intensive intervention is required.

246. The adoption of multi-disciplinary models of care would enable the social determinants of health to be better addressed and lead to better care and health outcomes. Such models would include youth workers, homeless support workers, men's health workers, women's health workers, school welfare and mental health staff, speech pathologists, early childhood workers and many more.

Social inclusion

247. Federal and state governments should jointly fund a social inclusion campaign that includes mass media social marketing and localised grassroots community education to promote social inclusion. DSQ and FAHCSIA should provide on-going funding to the Queensland Alliance to continue the Sector Development project for three years and enable expansion of its scope to every DSQ region.

Women's health

248. The National Women's Health Policy should acknowledge women's roles in the health of families and communities and so should specifically promote education and health literacy in girls.
249. The National Women's Health Policy must include goals for equity in health services and outcomes for women in rural and remote areas.
250. The ability of nurse practitioners, physician assistants and practice nurses to provide Well Woman Checks should be recognised, encouraged and promoted by the medical community and the public sector. Consensus should be reached by health professionals regarding the components of the Well Woman Check, based on the evidence provided by current literature. Practice guidelines for Well Woman Checks in Australia should be developed to ensure uniformity of health delivery for women and improved education. Health professionals involved in Well Woman Checks should be encouraged to provide information to patients regarding the procedures being performed, the implications of positive and negative findings, and the follow-up of results.

Workforce

251. The SOLS model of locum relief should be extended to include midwives and paediatricians, as a core component of the plan to improve rural maternity care.
252. The support mechanisms for allied health professionals in the Loddon Mallee Region of Victoria seem to be working well and should be replicated.
253. Given that over 50 per cent of allied health staff are not retained in rural and remote areas because of management issues, health service managers should give equal consideration and value to allied health professionals in terms of retention strategies and support as given to other health professionals within their area service.
254. Tertiary institutions should establish significantly more allied health training positions and ensure that 30 per cent of all places are allocated to rural students.
255. The Commonwealth should acknowledge the failure of past policies to address the rural medical shortage and pay more attention to how the system as a whole is funded to bring about fundamental change in the distribution of GPs (and other doctors) across Australia.

256. There is a need for improvement in the structure and approach to providing support and supervision for allied health students undertaking rural placements. There is additional scope to increase the regional training capacity for nursing and allied health students.
257. There is a need to address the maldistribution of medical workforce by creating rural opportunities for quality post-graduate training programs in rural/regional locations. The development of attractive rural post-graduate training opportunities will help retain older medical students in rural locations and prevent their return to metropolitan regions.
258. The capacity of rural, regional and remote areas to capture a fair share of the greater number of medical and other health graduates in the pipeline is a national policy emergency.
259. There is a need to re-evaluate the variables which influence student placement choices and future career intentions.
260. There is a need for a re-assertion of the vital importance of 'medical generalism', as represented by rural GPs and generalist-specialists, in order to support rural and regional communities into the future.
261. There should be better recognition of social workers' contributions in the health system, including monitoring of GPs from overseas and assessment of their competencies. Currently too much of the responsibility for the assessment and treatment of mental health issues is delegated to GPs.
262. The Australian Government should support postgraduate clinical training in order to upskill in an area of specialist practice (eg paediatrics). It should be aimed at young rural allied health professionals as a recruitment and retention strategy, and should be provided in collaboration with a tertiary institution.
263. Professional bodies and governments should support extension of MSOAP to allow multidisciplinary teams to go to communities to see patients locally, instead of individuals travelling to multiple destinations, especially as fuel costs increase.
264. Governments, workforce agencies and employers should create 'connectedness' by actively fostering relationships between health professionals, their rural and remote places, and their communities.
265. Medical Schools and the DOHA should give priority to longitudinal tracking of the movement of medical practitioners within rural areas and between rural and urban areas. It would allow better understanding of the reasons for gains and losses to the rural medical workforce. Combined with knowledge of characteristics of their training and personal background, this could yield valuable information on how to develop medical education programs to optimise entry into and retention within rural medical practice.
266. State and local government, universities and student networks should promote student workplace partnerships through private arrangements between students and private practice, managers who have special rural interests (thus providing students with early exposure to aspects of rural health), and wider availability of rural placements for medical and allied health students.

267. The Australian and State/Territory Governments should develop delivery of health service models for allied health staff that integrate the provision of both public and private services in order to provide more incentives for allied health to take up rural practice.